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ABSTRACT

Underutilization of mental health services is a function of the difference between actual prevalence of psychological dysfunction and need, and the number of treated cases. An extensive evaluation was conducted of the empirical literature on the underutilization of mental health services by lower socioeconomic status Mexican-Americans. The literature reviewed defined and provided evidence of Mexican-American underutilization of traditional mental health services. Significant barriers that hinder utilization were identified. They included Mexican cultural tradition, acculturation, the Mexican-American view of psychopathology and healing, socioeconomic status, level of psychopathology, the therapeutic relationship, and expectations regarding mental health services. It was also revealed that mental health agencies have attempted to enhance utilization by developing more professional sensitivity to the issues of acculturation and language differences. Research revealed that Mexican-Americans responded better to more problem-oriented treatment. Orientation programs, which provide both the Mexican-American client and the Anglo-American therapist with ways to better understand each other have also proved beneficial. (Sixty-five references are included.) (Author/NB)

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UNDERUTILIZATION OF MENTAL HEALTH SERVICES BY LOWER SOCIOECONOMIC STATUS MEXICAN-AMERICANS

A Doctoral Research Paper

Presented to

the Faculty of the Rosemead School of Psychology

Biola University

In Partial Fulfillment

of the Requirements for the Degree

Doctor of Psychology

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by

Emilio Mario Amigo

May, 1989

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UNDERUTILIZATION OF MENTAL HEALTH SERVICES

BY LOWER SOCIOECONOMIC STATUS

MEXICAN-AMERICANS

BY

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ABSTRACT

UNDERUTILIZATION OF MENTAL HEALTH SERVICES
BY LOWER SOCIOECONOMIC STATUS
MEXICAN-AMERICANS

Emilio Mario Amigo

The primary goal of this paper was to provide an extensive evaluation of the empirical literature on the underutilization of Mental Health services by lower socioeconomic status Mexican-Americans. The underutilization of Mental Health services is defined as a function of the difference between actual prevalence of psychological dysfunction and need, and the number of treated cases. The literature reviewed defined and provided evidence of Mexican-American underutilization of traditional Mental Health services.

Significant barriers that hinder utilization include Mexican cultural tradition, acculturation, view of psychopathology and healing, socioeconomic status, level of psychopathology, the therapeutic relationship and expectations thereof. Alternative resources for psychological assistance were also explored.

Mental Health agencies have attempted to enhance utilization by developing more professional sensitivity to the issues of acculturation and language differences. It has been found that Mexican-Americans repond better to more problem-oriented treatments. Orientation programs, which provide both the Mexican-American client and the Anglo-American therapist ways to better understand each other, have also proved beneficial.

Underutilization of Mental Health Services

by Lower Socioeconomic Status

Mexican-Americans

How do Mexican-Americans utilize Mental Health services available to them and how well does the Mental Health community service Mexican-Americans? To thoroughly explore these two issues many factors must be investigated. The Mexican-American sub-population in this country is growing rapidly. In fact, soon the city of Los Angeles will have more people claiming Spanish as their first language than those who claim to speak primarily English. If traditional Mental Health services are to meet the needs of this growing minority, an examination within the field must take place. This paper reviews the most recent and relevant literature.

The research covered in this paper addresses the reasons for apparent underutilization of Mental Health services by Mexican-Americans and the psychotherapeutic approaches with which to enhance the utilization of these services by Mexican-Americans.

First the definition of and evidence for underutilization is presented. The barriers to using Mental Health services by Mexican-Americans are also explored. These include Mexican cultural

tradition, acculturation level and views regarding psychotherapy and healing. Lower socioeconomic status, ethnicity and the client-therapist relationship, reported levels of psychopathology, and client attitudes toward psychotherapy all hinder utilization of Mental Health services. Mental Health service variables that account for underutilization by Mexican-Americans and alternative resources for emotional support provide further barriers.

Psychotherapeutic strategies to enhance utilization are examined. Sensitivity to the level of acculturation and to the language barriers are two such strategies. Treatment issues are also presented as are structural programs which orient the client and/or the therapist.

For each factor examined, supportive empirical findings are described and evaluated. In cases of conflicting data, the study with the highest methodological standards is focused upon.

Underutilization of Mental Health Services by Mexican-Americans

Underutilization Defined

True underutilization is a function of the difference between actual prevalence and the number of treated cases. Underutilization involves an indication that significant psychological needs exist within an ethnic minority group, such as Mexican-Americans, and at the same time an

underrepresentation of individuals seeking traditional Mental Health services exists.

Griffith (1985) set out to find the baseline measurement of psychological impairment to understand what the level for utilization should be for Hispanics and to determine relationships between impairment symptomology and sociodemographic characteristics which are unique to the Mexican-American population. He found that prior studies on underutilization assumed that the proportion of the psychologically impaired is comparable across racial/ethnic groups. Griffith empirically showed that Anglo and Mexican-American groups did not differ proportionally in anxiety, psychological dysfunction and depressive symptoms. Therefore there are unmet psychological needs within the Mexican-American community.

Evidence of Underutilization

The majority of research supports significant differences for the Mexican-American population and other populations in terms of the utilization of Mental Health services. In 1978, the ethnicity of patients treated over a three year period at community Mental Health facilities in Washington state was examined. Mexican-Americans were treated by the facilities in numbers proportionally less than their occurence in the

facilities' vicinity (Sue, Allen & Conaway, 1978). There is evidence to suggest that Mexican-Americans are underrepresented in terms of psychiatric hospital admissions. Acosta, in 1979, investigated admission rates into state and county psychiatric hospitals and found that although Mexican-Americans represented 21% of the general population, only 12.5% of the admissions were Mexican-Americans. In comparison, Blacks represented only 12% of the general population and yet had 26% of all the admissions for that period of time.

A survey was conducted in three suburban communities in southern California served by Pomona Valley Community Mental Health Center (Griffith,1985). Analysis of the service utilization statistics shows Mexican-Americans using Mental Health services proportionally less than other racial/ethnic groups. Bachrach (1975) indicated a lower utilization rate for Spanish-Americans than those for both white and non-white Americans.

Patterns of Mental Health service underutilization for Mexican-Americans have also been reported for California state Mental Health facilities (Karno & Edgerton, 1969); a San Jose, California, Mental Health center (Torrey, 1973); Denver facilities (Kline, 1969); services in Colorado and New Mexico (Weaver, 1973); Texas state mental hospitals

(Pokorney & Overall, 1970); and community Mental Health agencies in Seattle, Washington (Sue, Allen, & Conaway, 1978).

Because this underutilization of traditional Mental Health services has been so great, many Mexican-Americans have been unnecessarily vulnerable to the exacerbation of psychological dysfunction. In comparison to Anglo-Americans, Mexican-Americans were therefore more at-risk of developing psychological impairment symptomology due to these unmet needs (Griffith, 1985).

Reasons for this underutilization by Mexican-Americans of Mental Health Services and its components are complex and varied. The need to determine the relationship of psychological impairment symptomology to the availability and use of indigenous support systems for Mexican-Americans and Anglo-Americans is important in understanding why there is apparent underutilization of Mental Health services. One such support system is the Mexican-American family and it's tradition.

Barriers to Using Mental Health Services

Mexican Culture and Family

One reason for underutilization of traditional Mental Health Services by Mexican-Americans is the nature of the Mexican culture and family. To understand the Mexican-American or Hispanic client, one must gain an

appreciation of the Mexican culture and the institution of the Mexican family. Much of the writings in the 1960s and 1970s described the Mexican-American family as a large and cohesive kin group. The extended Mexican-American family was seen as a haven from threat and trouble and was thought to relieve emotional problems and lower the level of distress due to its extended composition (Eaton, 1978; Myers et al., 1975). Although this is presently a generally accepted belief, there has been little concrete data available to explore the structure, integration and operation of the Mexican-American family (Keefe, Padilla, & Carlos, 1979).

The Mexican-American family is certainly a by product of generations influenced by the strong and traditional Mexican culture. In looking at this culture one realizes the pervasiveness of an orientation toward the present rather than the past or the future. The understanding of "being" is to spontaneously express oneself through measurable accomplishment (Mirowsky & Ross, 1984). Also, Mexicans are more likely to believe in external control, which is a learned and generalized expectation that one has little control over meaningful events and outcomes in life. They are more likely not to attempt modification of the effects of their present environmental conditions. Internal sense of control has been strongly associated with competence, coping ability and relative

invulnerability to debilitating effects of stressful life events (Campbell, Converse, & Rogers, 1976). Because belief in external control is associated with psychological distress (Mirowsky & Ross, 1984), it would appear that Mexicans and Mexican-Americans may be more likely than Anglo-Americans to be distressed. Community Mental Health surveys present a mixed picture. Mirowsky and Ross (1980) found there to be no significant difference in level of distress among ethnic groups, including Mexican-Americans. However, Mexican culture and heritage were found to positively correlate with depression, but negatively correlate with anxiety.

Mirowsky and Ross (1984) attempted to explain the apparently contradictory findings regarding the impact of Mexican heritage on levels of distress. They administered face-to-face interviews in El Paso, Texas and Juarez, Mexico. The survey was a comparative, cross-sectional study of social stressors and psychological and physical symptoms among Mexican, Mexican-American, and Anglo adults. They found that Mexican heritage does tend to increase distress because of its association with belief in external control, but this tendency is counterbalanced by other aspects of Mexican culture (Pine, Padilla, & Maldonado, 1985). These factors include the mutual obligations of family and friends, and the maintenance of a strong support network, including extended family. It appears then, that the mutual

obligations in a social network may balance depression against anxiety and thus, in part, account for the emotional impact of Mexican culture.

Another study on Mexican-American family functioning was administered in the Santa Barbara, Santa Paula, and Oxnard areas of Southern California during the period of 1975 through 1977 (Keefe, Padilla, & Carlos, 1979). The percentage of Mexican-Americans in these areas was 21%, 44%, and 34% respectively. Results of this study show that Mexican-Americans go to local relatives for emotional help, although some expressed appreciable ambivalence due to a fear that the relative would get too emotionally involved in the person's life. Usually it would be one particular relative in whom the other family members confided. The quality of the advice was sometimes questioned by the recipient, but at least it tended to be supportive, attentive, and caring. One-fourth of the Mexican-Americans studied would seek the help of a physician for a psychological problem, and just less than one-fourth indicated that they would seek out a clergyman for the same thing. Only 4% reported that they would seek professional clinical counseling help, as compared to 21% of the Anglo-Americans. Anglo-Americans were more likely to go outside of their family for help.

Furthermore, Mexican culture and family issues are significantly

affected by the level of acculturation found in an individual and his family or community. The acculturation process for the Mexican-American is a significant barrier to utilization of Mental Health services.

Acculturation

In spite of their early roots and involvement in the history of the United States, Mexican-Americans have held close ties to their mother country and maintained their Spanish language and much of their cultural characteristics more so than many other ethnic groups that have emigrated to the United States. One reason is that the immigration process for the Mexicans has taken several decades. Mexican traditions are constantly being reinforced by recent immigrants. Also the survival of language and culture among the inflow of new Mexican immigrants is due in part to the close geographic proximity of Mexico and to many living in the same community or barrio. The cycles of stress and acculturation which most immigrant groups experience once in a major time period are thus repeatedly initiated among large subgroups of Mexican-Americans.

Mexican-Americans suffer from adjustment problems related to the acculturation process. These disturbances have been manifested in varying degrees of intensity by physical symptoms such as somatic disorders, hyperventilation, and body tension, and/or by psychological distress, such as

loss of self-esteem, anxiety, depression, fear, and alienation (Smith, 1985).

Burnam, Timbers, and Hough (1984) investigated loss of self-esteem. They found that self-esteem level was significantly affected by place of birth. Those Mexicans who emmigrated from Mexico experienced a stronger sense of success and achievement, having overcome difficult odds and circumstances to enter the United States. They also came with a strong sense of community since many attempts at emmigration were done with small groups of family and friends. Arriving in the United States meant a welcome relief from the often severe conditions of impoverishment. For them their point of reference was the poverty and limitations of their village. In contrast, those Mexican-Americans born in the United States were found to have lower self-esteem than recent Mexican-American immigrants. This was attributed to using the American society as a reference point which promoted the perception of a disadvantaged Mexican-American. Not having had the character building experience of emmmigrating from Mexico, these Mexican-Americans often compared themselves to Anglo-Americans who were less discriminated against and who frequently found higher paying work. Burnam, et al., raise an important point, which is that it makes a considerable difference in terms of self-esteem whether a Mexican-American was born in the United

States or in Mexico.

The Mexican-American client can best be understood when the impact of the acculturation process and the Mexican culture is likewise understood. In addition, acculturation and Mexican culture provide the Mexican-American with a unique perspective on psychopathology and healing.

Psychopathology and Healing

One overlooked fact is that culturally different patients such as Mexican-Americans who appear for outpatient or inpatient Mental Health services bring with them preconceived ideas and expectations about what constitutes illness, what kinds of treatment procedures are effective and correct and what kinds of services are most compatible with their cultural background and lifestyle.

In 1983, Maduro proposed numerous philosophical premises that influence Mexican-American beliefs and expectations regarding psychopathology and Mental Health. He noted that the mind and body are seen as inseparable, that is, there is no perceived dichotomy between emotional and somatic illnesses. Illness is a result of strongly experienced emotional states. In addition to these emotional states such as "bilis" (livid rage accompanied by revenge fantasies) and "susto" (natural awesome

fright), other factors such as "empacho" (dislocation of certain real or imaginary parts of the body) cause sickness. Mexican-Americans also believe in the balancing of the emotional, physical, and social aspects of life. Because the patient is seen as an innocent victim of malevolent forces in the environment, he or she is indulged by family and friends, allowed to regress, be passive and receive expected social support throughout the healing process. The family is considered to be responsible for the individual's healing. Another underlying assumption is that the natural world is not clearly distinguishable from the supernatural. Therefore religious beliefs need to be understood by the therapist and accepted as primary to the patient's view of the psycholgical or emotional symptomology. These premises are central to the Mexican-American's conception of psychopathology.

Lower Socioeconomic Status

Another barrier to utilization is the lower socioeconomic status as it affects level of psychopathology since the majority of studies on Mexican-Americans involve individuals of a low socioeconomic status. Lower socioeconomic status is strongly related to high levels of unemployment, higher population density per square mile, significant housing problems, discrimination, and prejudice. These factors are

consistent with the social causation theory of psychological dysfunction which purports that lower socioeconomic status affects psychological functioning in a negative manner regardless of ethnicity (Griffith, 1985).

In 1974, Dohrenwend and Dohrenwend compiled data from 33 different community studies and found that in 28 of them the the lowest class yielded the highest rates of psychopathology. Socioeconomic status is apparently inversely related to various measures of psychological disorder. In other words sociocultural conditions have measurable consequences reflected in the Mental Health differences to be observed within a population.

The causal interpretation of the relationship between low socioeconomic status and level of psychological dysfunction has been challenged by other researchers. The issue is whether this inverse relationship arises from the fact that low social status leads to dysfunctional symptomology (referred to as social causation) or whether a high degree of symptomology impairs the individual's ability to be upwardly mobile (social selection) (Dohrenwend & Crandall, 1970).

Wheaton (1978) measured socioeconomic status and psychological disorder symptomology at multiple points in time. Results from estimating a series of panel models incorporating unobserved variable specifications of

both socioeconomic status and disorder favored a social causation interpretation, with some needed modification. Social causation becomes more relevant as the socioeconomic environment becomes increasingly advantageous and provides opportunity for status advancement. In other words, the more the socioeconomic environment is active, expanding, and perceived as progressing rather than stagnating, the more that low status probably is experienced as a have-not position in the system.

Social class can indeed serve as a barrier against the utilization of Mental Health services. Traditionally, therapy has been available to middle and upper class individuals. Lower class individuals often receive less favorable clinical evaluations. Researchers have found significant differences as to treatment, disposition and outcome as a function of socioeconomic status. Gift, Straus, Ritzler, Kokes and Harder (1986) reported findings from a prospective follow-up study of a representative sample of first-admission psychiatric patients. Social status of the individual patient, social status of the patient's parents and social status associated with the patient's residential area were found to be correlated with psychological improvement over a two year follow-up period.

Level of Psychopathology

Some studies indicate that Mexican-Americans tend to have high rates of reported mental illness. This involves stressors associated with immigration, dislocation, culture shock, low educational accomplishment, discrimination, segregation, poverty and unemployment (Acosta, 1979; Maduro, 1983; Meadow, 1982). Making the situation even more difficult is evidence that Hispanics seek services only when the symptomology is rather severe (Maduro, 1983; Padilla, et. al., 1975; Sue & Morishima, 1982).

Furthermore, it has been reported that ethnic discrimination, in the delivery system of psychology and psychiatry, has led to an increase in Mexicans being diagnosed with serious mental disorders and inpatient treatment chosen over outpatient therapy (Murillo-Rohde, 1981; Padilla, et al., 1975). The Mexican-Americans were seen as less socially valuable, in terms of their contribution to society, than clients of the majority group . The non-Mexican-American therapist may feel frustrated and disinterested because low income Mexican-Americans traditionally are found to have low insight, poor verbal English fluency, and significant and numerous living problems (Acosta, 1977).

Ethnic differences among black, Hispanic, and white applicants for outpatient therapy using self-reported symptoms on the Symptom Checklist

90-Revised were examined in 1984 (Skilbeck, Acosta, Yamamoto, & Evans). All clients were from the low income social class. Hispanics generally reported higher levels of symptomology. This trend was consistent with the severity of the associated therapists' diagnoses for these same clients. Cultural and social factors have been found to affect diagnosis rates for women of different minorities. Hispanic women reported more symptomology than white or black women. Base rates of psychiatric symptomology of schizophrenia differed according to cultural and social factors as well (Adembimpe, Chu, Klein, & Lange, 1982).

Ethnic and social predictors of illness symptoms were investigated by Burnam, Timbers and Hough in 1984. Psychological distress was assessed with the Langner and the Demoralization scales. The Langner Scale is comprised of items that discriminate psychiatric patients from normal populations, with frequency of occurence functioning as the criterion of severity. The Demoralization Scale measured the intensity of the symptom as the criterion of severity. The results were that Anglo-Americans reported more symptoms that occurred infrequently, while the Mexican-American and Mexican subjects reported fewer symptoms but reported experiencing them more frequently.

J. Flaskerud, in 1986(a), investigated the comparison of diagnosis

and treatment of Anglo-American psychiatric patients to those of Black, Mexican, Vietnamese and Filipino patients. There were small differences noted among the groups but overall this lower class population received similar treatment regardless of race or ethnicity. Somatization among minorities was not supported in this study. Minority patients did not have more serious problems and there was no apparent discrimination related to whether inpatient or outpatient treatment was chosen.

A Texas State Mental Hospital study (Pokorney & Overall, 1970) compared ethnic groups on factor scores on the Brief Psychiatric Rating Scale which had been administered at intake. On variables that yielded significant between-group differences, Mexican-American patients exhibited the most severe scores. Differences persisted even when age, sex, marital status, divorce history, and educational attainment were statistically controlled.

Of course the question of whether there is a systemic phenomenon occurring that allows only the most psychologically dysfunctional Mexican-Americans to receive treatment persists. What happened to the less seriously ill Mexican-Americans? Perhaps the answer to this question is that the assessment measures of the severity of psychological disorders is biased against the Mexican-Americans; biased towards exacerbating the

actual symptomology. The structure of interview and evaluation measures may exagerate the appearance of Mexican-Americans' symptomology. Not only does ethnicity affect reported level of psychopathology but it also impacts how the Mexican-American client experiences the therapist and his role.

Ethnicity and Therapeutic Relationship

The Mexican-American client may mentally stereotype the Anglo-American therapist, viewing the therapist as cold, unkind, insincere and as a mercenary (Simmons, 1961). To the contrary, more recent studies (Acosta & Sheehan, 1976, 1978) reported that Mexican-Americans responded with more positive attitudes toward an audio tape of an Anglo-American therapist than toward Mexican-American therapists. Skill, understanding, and trustworthiness were attributed to the Anglo-American therapist. A self-stereotyping effect may occur due to less trust and credence in an expert therapist of their own ethnic identification.

Self-disclosure and how it relates to the therapeutic alliance and relationship is an important variable in assessing the quality of the therapeutic relationship for the Mexican-American client. Ethnic and acculturation differences in self-disclosure have been studied recently with significant results. Franco, Malloy, & Gonzalez (1984) analyzed the

self-disclosure patterns of Anglo and Mexican-Americans. They were analyzed according to frequency of reported self-disclosure, preferred topics (whether about taste, attitude, personality, or money) and preferred targets (whether to mother, father, male friend, or female friend). Administrator ethnicity and gender were varied so that the interaction of these examiner variables with subject gender and ethnicity could be analyzed. Subjects were 42 male and 116 female Anglo-Americans and 31 and 87 female Mexican-American freshman and sophomore students at a Southwestern university whose participation was voluntary. They were administered the Jourard's Self-Disclosure Questionaire and the Acculturation Rating Scale for Mexican-Americans by four graduate students easily identified as either Anglo or Mexican-American; male or female. Franco, et al., found no ethnic differences with regard to the dimension of self-disclosure. The level of acculturation and the ethnic mix of the therapeutic dyad were considered the most significant variables. Hispanic clients tended to report more disclosures to Anglo-American therapists. Interestingly, Anglo-American clients tended to report more disclosure to an Hispanic therapist. Apparently the subjects perceived themselves to be more open with people who are clearly different on some ethnic/cultural dimensions. The Social Exchange theory accounts for this by

considering the reward and cost factors in the past, present, and future social exchanges. Under these circumstances it appeared safer to self-disclose to someone outside of one's own ethnic group. It should be noted that this study focused on reported disclosure, not on observed self-disclosure. Observation of self-disclosures would be an excellent area of future research since it is possible that reported and actual incidence of self-disclosure may vary.

Levine and Franco (1981) also compare Anglo-Americans and Mexican-Americans on overall frequency of reported self-disclosure as well as preferred topics and preferred targets of self-disclosure. Anglo-Americans indicated more disclosure than Hispanics. Male Hispanics' disclosure was particularly low, unless the therapist was an Hispanic female, in which case disclosure was high. Unlike Burnam, et al., these findings contradicted the Social Exchange theory explanation. It appears that ethnicity and self-disclosure studies have shown few Main effects for ethnicity. At this time it is inconclusive just how and if so, why ethnicity correlates with levels of disclosure. Unlike self-disclosure, Mexican-American ethnicity has strongly impacted the Mexican-American's expectations regarding traditional Mental Health services.

Expectations Regarding Mental Health Services

It would appear that ethnic minority groups differ from each other and Anglo groups according to why they utilize Mental Health services (Evans, Acosta, Yamamoto, & Hurwicz, 1986). Applicants for outpatient psychotherapy at a large urban medical center were invited to participate in a study of therapy services. The adult psychiatric outpatient clinic within this medical center was located in an ethnically diverse and generally low-income status region. The study found that Anglo-Americans come to therapy because they see the problem as residing within themselves, and do not necessarily believe the problem to be serious. They want their role as clients to be active, collaborative, and more cognitive than emotional. Mexican-Americans, unlike Anglo-Amercians, see the problem as residing outside themselves and they stress action by the therapist with minimal or no involvement on the part of the client. This study supports what Gould wrote 20 years earlier. In describing low income and minority clients based on his clinical experience, Gould (1967) said that low income clients were more action-oriented than verbal, extrospective rather than introspective, oriented toward problem and symptom rather than directed toward personality change; poorly educated; relatively unimaginative and less given to fantasy and, in a doctor-patient relationship, expect more immediate

direct results. They desire specific behavior change in their marriage or job and want their health to improve if the complaint is a somatic one. They expect to be treated by physical means rather than by talk.

Contrary to Gould's assessment, Frank, Eisenthal and Lazare (1978) reported no conclusive evidence was found to indicate that lower class patients need, expect, or want anything different form their middle- and upper-class counterparts. Only in terms of treatment disposition and outcome did they note any social class differences. The reason for this may be that they isolated over fourteen categories of requests, thereby reducing the chances for any significant differences between social classes to be noted. Had they narrowed the number of categories, there may have been more significant differences between the social classes.

Another study which disagreed with Gould's characterization of the low income minority client, done just two years after Gould's study, consisted of a survey of 400 Mexican-Americans and 200 Anglo-Americans in Los Angeles. Karno and Edgerton (1969) found remarkably few statistically significant differences between the interview responses of Mexicans and Anglo-Americans as measured by perceptions and definitions of mental illness. Both groups expressed equally favorable attitudes towards the efficacy of psychiatric treatment (Karno & Edgerton, 1969).

Most of the literature indicate that Mexican-Americans as an ethnic minority group do have unique expectations for therapy from those of Anglo-Americans. Evans, et al., focused on three factors as opposed to the fourteen categories examined by Frank, et al.. Because the three factors were the same found by Lazare in 1977, there appears to be more construct validity present. These three factors were: a.) "The problem is seen as residing within the patient, is felt to be serious, has an affective-urgent quality, stresses the desire for someone to take over in a manner which is both active and giving, b.) The problem is seen as residing within the patient, is not necessarily felt to be serious, and asks that the patient's role be active, collaborative, and more cognitive than emotional, c.) The problem is seen as residing outside the patient and stresses action by the therapist with minimal or no involvement on the part of the patient." A disproportionately large percentage of Hispanics, 26%, as compared to 15% of Blacks and only 9% of Anglo-Americans came for reasons that define Factor III. Therapists working with Mexican-Americans need to have this information if they are to be effective in treating this ethnic minority group. In addition to this information, therapists also need to be aware of other miscellaneous variables that account for underutilization.

Variables That Account for Underutilization

The Special Populations Task Force of the President's Commission on Mental Health (1978) states that ethnic minorities "are clearly underserved or inappropriately served by the current Mental Health system in this country." It has also been reported that Mental Health professionals are simply not prepared to service ethnic clients' needs at public Mental Health facilities (Acosta & Yamamoto, 1982; Acosta, Yamamoto, & Evans, 1982).

For the Hispanic, not unlike other minority groups, there is often stigma and shame associated with mental illness (Sue & Morishima, 1982). In addition, Hispanics may believe that mental illness is a result of shameful or immoral thoughts and behavior. Mental health is believed by Hispanics to be achieved by thinking pleasant and serene thoughts, not by dwelling on problems or morbid thoughts. Traditional psychotherapy appears to be antithetical to these perceptions (Sue & Morishima, 1982). Because they fear that they will bring shame and dishonor to their family (Murillo-Rohde, 1981; Sue & Morishima, 1982), it would be risky to implicate one's family since family inheritance is considered a powerful means of acquiring mental illness (Sue & Morishima, 1982). Hispanics may deny and hide any evidence of mental illness within themselves or their

families.

The unresponsiveness and inaccessibility of the Mental Health service system, as evidenced by the lack of Spanish-speaking and cross-culturally aware therapists, has raised cautiousness within the Hispanic community. For example, if the facilities are not conveniently located, clients do not use them. Many Mexican-Americans refrain from seeking Mental Health assistance because of transportation difficulties, expenditure of time, and discomfort over entering unfamiliar neighborhoods. Safety may also be an issue, as may the potential discomfort of being in the presence of a majority of other ethnic/racial groups (Padilla, et al., 1975; Sue & Morishima, 1982; Windle, 1980). Minority clients are often not able to visit a Mental Health center during regular business hours, and thus, providing evening and week-end services would be expected to increase utilization. Additionally if minority clients do arrive without an appointment, many agencies do not have the structure to accomodate the walk-in client (Acosta, 1980; Sue & Morishima, 1982; Windle, 1980).

These barriers to the utilization of Mental Health services are further strengthened by alternative resources available for the emotionally troubled Mexican-American.

Alternative Resources

The Hispanic client utilizes informal support systems before considering formal ones. A crucial component of the formula used to derive a Mental Health need rate is the extent to which the "needy" or underutilizers rely on informal, naturally occurring personal networks for emotional support (Albee, 1982). Unfortunately both utilization and epidemiological studies have essentially ignored this factor. These informal support systems are typified by non-institutionalized means of providing help, service rendered by Hispanics within the community, action-oriented treatment that stresses cures with a cultural base, sliding scale fees or credit, and culturally relevant and meaningful diagnosis and language (Humm-Delgado & Delgado, 1986). Griffith (1985) goes on to say that serious consideration should be given to reexamining the appropriateness of the blanket term "underutilization" to characterize Mexican-American Mental Health service use. Perhaps multi-utilization or hybrid-utilization would better describe the Mexican-American population (For the sake of continuity, underutilization will continue to be used since this is found throughout relevant literature). For example, many Hispanics prefer to visit their family physician or a traditional healer before they would step foot into a Mental Health center (Keefe, et al., 1979; Maduro,

1983). The family church's clergy provide a source of guidance and direction for solving personal and psychological problems (Griffith, et al., 1984; Keefe, et al., 1979).

One cannot treat Mexican-Americans without understanding the cultural and religious history of folk psychiatry, better known as folk-healing or "curanderismo." The curandero represented a religious person who had healing authority and power through such things as suggestion, persuasion, advice-giving, rituals, massage, herbs, prayer and the assessment of guilt and sin. Although not as many as once believed go to see a traditional healer (2% as reported by Padilla, et al., 1976), the healer is a person who shares in the client's world views, who can make seemingly appropriate diagnoses, whose treatment is both practical and symbolic and whose focus is on the physical, social and spiritual dimensions. Mexican-Americans most easily transfer the authority traditionally given to the curandero to a physician who offers cures rather than a therapist who offers talk-therapy (Edgerton, Karno, & Fernandez, 1970). The Anglo-American version of the curandero might be chiropractics or transcendental meditation. The point is that there are comparable nonpsychological forms of treatment for the Anglo-American population.

Treatment of psychiatric disorders by family physicians is an

important factor in Mexican-Americans' underutilization of Mental Health services (Edgerton, Karno, & Fernandez, 1970). One reason that a physician is approached for symptoms of mental illness is because emotional and psychological distress is not distinguished from somatic illness; rather such distress is attributed to somatic or organic processes (Maduro, 1983). Emotional states are expressed as specific disease entities or physical symptoms, some of which are considered culture specific syndromes (Weaver & Sklar, 1980). For example, in Hispanics, depression is most readily expressed in body aches, feelings of weakness, exhaustion or fatigue headaches. Anxiety is often expressed as heart palpitations., dizziness, and fainting (Abad, Ramos, & Boyce, 1979).

In a preliminary survey of over 600 Mexican-Americans and Anglo-Americans in three California communities, Padilla, et al., (1979) sought to assess the percentage of both Mexican-Amercians and Anglo-Americans who utilized extra-familial emotional support. The data collected was for the period of the previous year. Mexican-Americans used a relative at a significantly higher rate (36%) than did Anglo-Americans (22%). Similarly, 21% of the Mexican-Americans used a doctor while 12% of the Anglo-Americans did. Physicians are most often consulted for emotional problems not recognized as being family related, especially those

that have physical symptoms. Mexican-Americans frequently believe that medication is a required form of treatment.

In addition to understanding how the Mexican-American client contributes to the apparent underutilization of traditional Mental Health services, there is a large body of research indicating that therapists often fail to provide culturally sensitive perspectives and techniques.

Strategies to Enhance Utilization

An important explanation for service delivery difficulties involves the cultural insensitivity of traditional Mental Health services and the lack of culturally responsive forms of treatment. In fact, most therapists know very little about cultural backgrounds and lifestyles of various ethnic-minority groups; instead, their training has been focused on the middle class Anglo-American client (Wyatt & Parham, 1985; Bernal & Padilla, 1982). Similarly, the treatment modalities offered in traditional settings lack the cultural sensitivity which would enhance their effectiveness.

Sensitivity to Level of Acculturation

In deciding upon a Mental Health services approach, the therapist must take into account such factors as the client's level of acculturation into the white majority cultural system and the client's socioeconomic

status. To what extent is the client bicultural or experiencing cultural contradictions? It is important for the therapist to understand several key acculturation issues: (1) the value patterns of the client's culture of origin; (2) where the client is in the acculturation process, for instance what values the client has changed from his or her culture of origin and what values he or she has retained at the time of the therapeutic intervention; and (3) at what point the client is in conflict with either mainstream American values or those of his or her culture of origin. In working with acculturation issues, the therapist's initial therapeutic task is to help the client determine where there are value conflicts, to gain insight regarding the impact of value conflicts on his or her behavior, and to facilitate the resolutions of these conflicts (Smith, 1985).

In 1978, the Special Populations Task Force of the President's Commission on Mental Health reported that "Services to be provided for the special populations should be delivered ... by persons who share the unique perspective, value system and beliefs of the group being served." Acosta in 1979, made several recommendations which he believed would significantly reverse the underutilization of Mental Health services by Mexican-Americans. Therapists in general need to be familiarized with information on ethnic minority groups, including the low-income

Mexican-American group. They need sensitivity training regarding social class dynamics and the cultural disimilarities found among ethnic groups and should be taught Spanish. Physicians need to be educated as to how to refer a Mexican-American to Mental Health services. And, last but not least, a need exists for a greater number of trained Mexican-American therapists.

Several researchers have found that Hispanics average fewer treatment sessions, higher drop-out rates, and generally use few of the mental health services available to them (Barrera, 1978; Keefe, et al., 1979; Griffith, 1985; Padilla, et al., 1975). Flaskerud (1986b) examined the relationship between a culture-compatible approach to Mental Health service and utilization as measured by dropout and total number of outpatients visits. This study showed that a culture-compatible approach was proven to be effective in increasing client satisfaction with treatment delivered by the therapist. Four public Mental Health agencies were included in the sample. They each served principally different ethnic groups, with one of them servicing Mexican-American clients and another servicing a white/mixed ethnic population was used as the control group.. A sampling frame was established for each agency. Data were collected from subjects' clinical records and included sociodemographic characteristics of the client, psychiatric diagnosis, identification of problems addressed, services

provided, frequency and duration of treatment and the absolute number of sessions. Data were also collected on agency and community characteristics, such as ethnicity/language of therapists, availability of services, and racial/ethnic background of clients.

Agencies were then given a culture-compatibility score for each of nine components. The agencies were scored for therapists who share the culture (ethnic/racial background) of the clients, therapists who share the language or language style of the clients, flexible hours and appointments, and use of brief therapy. There were no significant correlations between total culture-compatibility and dropout status or any of the culture compatibility components and dropout status. Of all the culture-compatibility components, language match of the therapist and client came closest to statistical significance in relationship to clients remaining in therapy ($r = 0.11$, $P = .055$.) This lack of significance can be explained by having given equal weight to the arbitrarily chosen culture-compatibility components when in reality this is not the way the components impact psychotherapy. Also perhaps other measures could have been used to measure utilization, such as symptom manifestation or impairment of functioning. In addition, clinical records are not necessarily the best instrument on which to base information. More research in this

area is definitely needed.

Sensitivity to Language Barriers

Some researchers take a more radical position and believe it is essential that therapists share the culture (ethnic/racial background) of the clients (Marcos, 1976). Equally important to them is for the therapist to share in the language or language style of the clients. Because of the geographical proximity of Mexico and the United States, Mexican-Americans tend to experience gradual acculturation. This allows for maintaining close emotional ties to their mother country as well as holding on to Spanish as the primary language. For this reason many Mexican-Americans consider Spanish their primary language. If the therapist speaks Spanish it can support a common understanding of attribution and treatment of mental illness, of self-disclosure and expressive styles, of the importance of the family in illness states and treatment, as well as minimize problems in assessment, process, and outcome (Barrera, 1978; Maduro, 1983; Sue & Morishima, 1982). The availability of bilingual-bicultural staff may have an important impact on Mexican-American Mental Health service utilization. Unfortunately, Ruiz (1971) found that only .54 % of the American Psychiatric Association and .87% of the American Psychological Association membership were Spanish-surnamed professionals residing in the United

States. This is a longer term solution but for now it will be up to non-Mexican-American therapists to provide more adequate treatment to Mexican-Americans. Understanding Spanish may help bridge the culture gap.

Language barriers have been found to exacerbate ethnic discrimination as mentioned earlier, and to also affect the determination of psychopathology during initial evaluation and in ongoing therapy (Marcos, 1979; Sue & Zane, 1987). In 1973, Puerto Rican bilingual schizophrenic patients were judged by raters to have more psychopathology when the interview was in English as opposed to Spanish (Marcos, Alpert, Urcuyo, & Kesselman, 1973 a & b). Based on their examination of psycholinguistic studies and on their own experimental work with schizophrenic patients, Marcos and his co-investigators have argued that bilingual patients who are dominant in a second language, for example Spanish, may show "affective detachment." When the patient has to mentally translate before speaking, it can inhibit emotional expression. Evaluations that assess severity via interview methods can mistakenly interpret the characteristics of speaking an unfamiliar language as indices of psychological disorder. This has also been evident in the area of personality testing, since speaking in a second language inhibits the formulations of concepts and spoken words (Padilla, Alvarez, & Ruiz, 1975) and therefore affects the responses given in these

tests.

Treatment Issues

The referral of clients to agencies which deal with social, economic, legal and medical problems might enhance utilization of services. Because of the prevalence of the lower-class lifestyles and its limitations among Hispanics, the interfacing of these services would probably help to normalize Mental Health service as just one facet of social assistance. This is especially valid in light of the finding that Hispanics often do not differentiate lifestyle-related problems from psychological disturbances (Acosta, 1980; Sue & Morishima, 1982; Windle, 1980).

For many Hispanics, the family is the most important resource in the care of ill family members. Therefore the use of family in the therapy process may encourage utilization. The extended kin network can be used therapeutically. Multi-generational family therapy would be one example of this approach. Of course, the treatment modality would have to be congruent with cultural expectations and practices (Keefe, et al.; Sue & Morishima, 1982; Weaver & Sklar, 1980).

When dealing with Hispanic clients, a Crisis-oriented style of therapy appears to be effective. This involves a focus on the situation or problem. Excessive self-disclosure presents problems for the Hispanic

client, especially if it involves exploration of disturbing thoughts and affect. Brief therapy can be active, immediate, directive, and supportive, with a focus on the specific present complaints, since concrete goals and outcome are desired by the client. This does not allow for the very threatening process of the therapist's reinterpretation (Sue & Morishima, 1982). Also, Hispanic clients value heirarchical (role-structured as opposed to egalitarian) relationships (Szapocznik, Santisteban, Kurtines, Hervis, & Spencer, 1982).

Given Hispanics' preference to utilize physicians and "Curanderos" or traditional healers, it would be wise for the therapist to become aware of these individuals in the neighborhood as a way of expanding the community referral network. A referral network would provide a way to assess the legitimacy of these practices in terms of being available for consultation for treatment.

Concurrent with the research that has been done on how therapeutic effectiveness can be enhanced through culturally-compatible components, there has been examination of the formal orientation of the therapists into the characteristics of the Hispanic client.

Therapist Orientation

The development of orientation programs to help the therapist better understand the Hispanic client's needs, cultural background, and expectation of working class patients is needed. In 1984(a) research was completed (Evans, Acosta, Yamamoto, & Skilbeck) which found that patients seen after therapist orientation were more satisfied with the services, felt better able to handle problems, felt more likely to seek therapy for future problems, and felt more strongly that their needs for clinic services had been met than the patients seen by therapists before orientation. After implementing a brief seminar with correlated reading materials designed to modify the therapist's behavior toward low-income and minority clients, Evans, et al., showed more favorable therapeutic outcomes and patient satisfaction.

As part of a larger National Institute for Mental Health study, 29 psychotherapists who were beginning training at a large urban psychiatric outpatient clinic participated in a special orientation program. The orientation program had the following objectives: First, to increase the therapists' knowledge of low income and minority patients; second, to increase the therapists' sensitivity to minority patients' requests and problems; and, third, to increase the effectiveness of the therapeutic

encounter. The majority of therapists acted as their own controls; they saw patients before and then after participating in the orientation program. Data indicated that therapists improved significantly in knowledge, sensitivity, and effectiveness as a result of the therapist orientation program. There appeared to be no significant link between patient satisfaction and therapist experience, patients' ethnicity, and patients' orientation to psychotherapy.

Client Orientation

The need for an orientation program for Mexican-American clients has been shown by low-income and minority clients who experience dissatisfaction with psychotherapy due to unmet expectations about the appropriate role of the psychotherapist (Yamamoto, Acosta, Evans, & Skilbeck, 1984). There is often disagreement with their therapist over expected rate of progress in treatment and confusion about their own role and responsibilities as clients (Acosta, 1979). Also, it has been shown that treatment choices, attitudes and behavior of the psychotherapists contribute to client dissatisfaction (Kline, Acosta, Austin, & Johnson, 1980; Acosta, 1977). Psychotherapeutic ignorance on the part of the client concerning the process of therapy needs to be dealt with and remedied.

As a result of these findings, Acosta, Yamamoto, Evans, Skilbeck,

(1983) developed another orientation program where Hispanic clients were involved in an audiovisual program where they were instructed on how psychotherapy leads to more knowledgable and more positive attitudes toward psychotherapy. They found that the more informed of the therapeutic process they were the more satisfied they were with the treatment. The role and utility of brief orientation for low income Mexican-American patients is presently the most effective intervention for enhancing the utilization of Mental Health services. This program of orientation needs to have a broader application across all agencies that service Mexican-Americans.

Conclusion

In summary, underutilization has been defined as it relates to Mexican-Americans and the utilization of traditional Mental Health services. There has been significant data to support the notion that Mexican-Americans actually do underutilize the Mental Health services available to them. This underutilization can be attributed not only to the culturally-derived biases against Mental Health services but also by the unresponsiveness and inaccessibility of these facilities. A number of barriers have been explored in an effort to better understand the underutilization of Mental Health services by Mexican-Americans. One such

barrier presented here is the role that the Mexican-American culture and heritage play in developing certain biases related to seeking help from Mental Health facilities. The acculturation level for Mexican-Americans positively correlates with utilization. This subsequently affects the view of psychopathology and healing. The less one has acculturated to the American culture, the more dependent one will be on Mexican cultural tradition to explain and treat psychological difficulties. Lower Socioeconomic status correlates significantly with such factors as severity of psychological symptomology, treatment choice, and treatment outcome. Mexican-Americans as an ethnic minority group tended to present the most severe psychological symptomology. This may be a function of a generally slow acculturation process, which inhibits the Mexican-American in his utilizing traditional American Mental health services and also the lack of cultural and language sensitivity on the part of the Mental Health provider agencies.

There is conflicting data regarding whether minorities actually experience more psychological symptomology. Some researchers state that Mexican-Americans experience greater levels of psychological dysfunction relative to the general population, while other researchers state that it is equal across ethnic boundaries but that Mexican-Americans underutilize the

Mental Health services available to them and therefore have a tremendous amount of unmet psychological needs.

The actual client-therapist relationship has been investigated in terms of how the Mexican-American experiences the therapeutic relationship with Mental Health service providers. Recent studies indicate that the Mexican-American client has a fairly positive view of Anglo therapists. Attitude toward the therapist and level of self-disclosure has been explored in the literature with little agreement This may be due to the reliance on self-reports used to assess levels of self-disclosure.

In spite of the many factors which interfere in the utilization of Mental Health services, a portion of the Mexican-American community do utilize these services. These factors were also found to be different than those for white and black Americans. Mexican-Americans seek more of a problem-solving approach by the therapist.

Often the Mental Health agency provides barriers to utilization by the very nature of its structure, ie. lack of Spanish speaking staff and lack of intercultural awareness training by the therapists. For these and other reasons the Mexican-American usually seeks out help from informal resources before they approach formal ones. The cultural significance of Mexican-folk "psychiatry" used for generations, the tendency to seek out

medical help for psychological problems, and the emotional support provided by the extended Mexican-American family network provide an important backdrop for the underutilization of traditional Mental Health services.

Recent research has not only focused on the underutilization problem but also on some proposed strategies designed to enhance the utilization of Mental Health services. A major emphasis has been on the development of culturally compatible psychotherapy. This has tended to be an educational approach to make the therapists sensitive to the cultural and acculturation issues present when treating a Mexican-American client. In addition, the training for sensitivity to the language barrier has helped client satisfaction and therapeutic effectiveness. An increase in the prevalence of Mexican-American therapists in the Mental Health field would certainly prove advantageous for Mexican-American clients.

Among the psychotherapeutic approaches studied, it seems that a Crisis-orientered approach best fits with the needs and preconceptions of the Mexican-American client. Using this model, the therapist would be structured, authoritarian and surface-problem oriented. The improvement of therapeutic techniques is equally needed along with a more culturally compatible approach.

The implementation of orientation programs for both

Mexican-American clients, and the therapists treating them, have also been found to enhance favorable therapeutic outcomes and patient satisfaction.

Certainly there is a tremendous need for more effective treatment for the Mexican-American. The barriers are formidable, but the development of strategies has been promising. The Mental Health community must continue to address and meet the unique needs presented by specific ethnic minority groups, such as the Mexican-Americans.

What Barrerra said ten years ago still applies today:
"We need to question seriously and seek empirical validation for factors that have been proposed to account for underutilizaion. Given a social context of unresponsive services and a notable absence of bilingual-bicultural professionals, factors such as negative attitudes toward Mental Health care and the subsequent utilization of non-mental health professionals can conceivably be viewed as results of inadequate service rather than causes of underutilization. Striving to make Mental Health service utilization rates by Mexican-Americans comparable to other ethnic groups should not necessarily be the ultimate goal of community Mental Health workers, but the availability of relevant, effective services could likely increase utilization and serve a constructive function in Mexican-American communities.

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